Faith-based health care 2

Controversies in faith and health care

Andrew Tomkins, Jean Duff, Atallah Fitzgibbon, Azza Karam, Edward J Mills, Keith Munnings, Sally Smith, Shreelata Rao Seshadri, Avraham Steinberg, Robert Vitillo, Philemon Yugi

Differences in religious faith-based viewpoints (controversies) on the sanctity of human life, acceptable behaviour, health-care technologies and health-care services contribute to the widespread variations in health care worldwide. Faith-linked controversies include family planning, child protection (especially child marriage, female genital mutilation, and immunisation), stigma and harm reduction, violence against women, sexual and reproductive health and HIV, gender, end-of-life issues, and faith activities including prayer. Buddhism, Christianity, Hinduism, Islam, Judaism, and traditional beliefs have similarities and differences in their viewpoints. Improved understanding by health-care providers of the heterogeneity of viewpoints, both within and between faiths, and their effect on health care is important for clinical medicine, public-health programmes, and health-care policy. Increased appreciation in faith leaders of the effect of their teachings on health care is also crucial. This Series paper outlines some faith-related controversies, describes how they influence health-care provision and uptake, and identifies opportunities for research and increased interaction between faith leaders and health-care providers to improve health care.

Published **Online**
July 7, 2015
http://dx.doi.org/10.1016/S0140-6736(15)60252-5

This is the second in a **Series** of three papers about faith-based health care

Institute for Global Health, Institute of Child Health, UCL, London, UK (Prof A Tomkins FMedSci); **Partnership for Faith and Development, USA** (J Duff MPH); **Islamic Relief Worldwide, Birmingham, UK** (A Fitzgibbon BsocSci); **UNFPA, New York, NY, USA** (A Karam PhD); **University of Ottawa, Ottawa, ON, Canada** (Prof E Mills PhD); **Buddhist Healthcare Chaplaincy Group, London, UK** (K Munning BSc); **UNAIDS, Geneva, Switzerland** (S Smith MSc); **Azim Premji University, Bangalore, India** (Prof S Rao Seshadri PhD); **Hebrew University-Hadassah Medical School, Jerusalem, Israel** (Prof A Steinberg MD); **Caritas Internationalis, Geneva, Switzerland** (R Vitillo MSW); **and Daystar University, Nairobi Kenya** (P Yugi PhD)

Correspondence to:
Prof Andrew Tomkins, Institute for Global Health, Institute of Child Health, UCL, London WC1N 1EH
a.tomkins@ucl.ac.uk

Introduction and ethics

More than 80% of the world's population reported having a religious faith,[1,2] but attribution of individual health-related viewpoints to this faith is very difficult because of variations in acceptance of the authority and interpretation of sacred texts and viewpoints that might be substantially modified by culture, education, economics, politics, and laws. We describe a series of common religious faith-related controversies in health care, reviewing some teachings within the different faiths. We also examine ways in which faith-inspired groups are advocates for, and provide, health-care services, and we make a plea for improved analysis and documentation of faith and health-care interactions to provide improved health-care services, especially for marginalised populations.

Codes of medical ethics can be considered on four levels: motivation; the source of reference and method of analysis; the ethical principle, theory, or value; and the consequences. Secular ethics is based on humanist values whereas faith-based ethics is based on sacred texts and teachings that are interpreted by faith-grounded experts.

The humanist approach has four fundamental principles:[3] autonomy (recognition that every person has intrinsic value and dignity, often viewing autonomy as the most important ethical principle), non-maleficence (do no harm), beneficence (the moral obligation to help others in need), and distributive justice (which requires that rights and assets should be distributed in an equitable and appropriate manner within society). Faith-based ethics and secular bioethics share many principles, but differ in several ways.[4] Faith-based ethics give varying weight to each of the previous four ethical principles. A high value on the sanctity attributed to human life might conflict with expectations of rights and emphasises the need for mutually shared values and solidarity, which might lessen the overriding importance of autonomy. Ethical issues are also important, though less frequently discussed, in public-health medicine and health-care policy.[5]

Faith-linked controversies

Family planning

Different viewpoints exist on when human life begins. Buddhists,[6] Catholics,[7] and Hindus[8] teach that human life starts at the moment of conception. Protestants vary; some believe that human life starts at conception whereas others believe it starts at implantation or even later.[9] Islam teaches that human life begins after 4 months of pregnancy, with the infusion of the spirit into the fetus.[10] Judaism teaches that human life is progressively acquired, starting 40 days after conception.[11]

Many Buddhists oppose contraceptive methods that prevent implantation, including intrauterine devices and the emergency contraceptive pill.[12] Catholics teach that couples should use natural family planning by restricting sexual intercourse to infertile periods in the woman's menstrual cycle.[13] Protestants accept oral or injectable contraceptives and condoms, but vary on their acceptance of intrauterine devices and the emergency contraceptive pill.[9] Hinduism has no injunctions against contraception.[8] Muslim opinion on contraception varies, a minority arguing that it is categorically prohibited, whereas the main opinion allows contraception, permitting oral

Search strategy and selection criteria

We searched PubMed, PsycINFO, and CINAHL for articles published in English between Jan 1, 1975, and Dec 31, 2014 with the search terms "faith", "religion", "ethics", "controversies", and "health care". We also searched websites of faith-based and secular organisations with expertise and experience in religious faith and health care.

Key messages

- More than 80% of the world's population report having a religious faith
- Faith-linked controversies in health care are often closely linked with culture, social factors and politics; precise attribution is difficult
- Child protection practices—child marriage, female genital mutilation and immunisation—vary between and within faith groups
- Faith groups differ in their support for health care practices including family planning, sexual and reproductive health, HIV care and harm reduction
- Notwithstanding some differences, there is increasing documentation of different faith groups working together to achieve considerable improvements in health care
- Policy makers and Faith Leaders strongly influence the provision and uptake of health care but largely work independently of each other, often lacking knowledge and appreciation
- Robust research is urgently needed on the interface between faith and health care in order to improve provision and uptake of health care, especially for marginalised populations.

and injectable contraceptives and condoms.[14,15] Judaism accepts oral contraceptives and intrauterine devices as the preferred contraceptive methods when contraception is sanctioned by Jewish law, followed by diaphragm and rhythm methods; condoms are forbidden.[16] Acceptance of family planning can be strongly supported or discouraged by the teaching and personal influence of faith leaders.[17]

Faith-based family planning services usually operate within national government frameworks, but there is little assessment of how much delivery of information, services, and supplies is influenced by a faith perspective. In particular, disappointingly little assessment has been done of the content, coverage, and effect of faith-based family planning services for populations in sub-Saharan Africa.

Abortion and artificial reproductive technology

All major religious faiths oppose abortion for sex selection. Faith-based viewpoints vary on abortion for preservation of maternal life in severe illness, which is unacceptable to the Catholic Church. Faith groups also vary in their viewpoints on abortion for pregnancies that might contribute to psychological ill health.

Modern technologies can increasingly diagnose and treat fetal abnormalities in utero, but some clinicians might recommend abortion. Catholics teach that prenatal diagnosis is acceptable to enable procedures that treat the human fetus, but abortion is not acceptable.[18] Many Buddhists reject abortion for fetal abnormalities, maintaining that meaningful life is possible, even for children with severe disability.[12] Protestants vary; some support early detection of, and abortion for, abnormalities that lead to disability, such as Down's syndrome, but others do not.[19,20] Hindus also vary, making their decision according to what is thought to be least harmful to the mother, the fetus, and society.[21] Some Islamic scholars permit abortion for conditions such as thalassaemia; decisions over abortion for serious fetal abnormalities can be informed by the belief that ensoulment occurs 120 days after conception.[14] In Judaism, many rabbis accept abortion before 40 days of gestation for serious fetal abnormalities, and after that abortion is only permissible if fetal malformation is incompatible with life. Preservation of maternal life is highly regarded in Judaism when managing life-threatening conditions in pregnancy. There are few data for the influence of faith-based viewpoints of patients on their decision to abort for fetal abnormality or the provision of abortion services for fetal abnormalities by faith-inspired health-care providers.

Modern artificial reproductive technologies are increasingly available to previously infertile couples. Faith leaders in Buddhism, Protestant churches (variably), Hinduism, Islam, and Judaism support in-vitro fertilisation and artificial insemination by a woman's husband,[10,11,22] but generally oppose artificial insemination by a donor.

Child marriage

The UN Convention on the Rights of the Child (1990) defines a child as anyone younger than 18 years, and yet a third of the world's girls are married before the age of 18 years and one in nine are married before age 15 years. The adverse effects of pregnancy in children are substantial.[23] Historically, many faith groups have supported existing customs around child marriage, citing the benefits in terms of chastity and fidelity. However, since the early 20th century, many faith groups have encouraged changes in law and conformity to state laws on age of marriage. Catholic, Protestant, Hindu (including the Arya Samaj and the Brahmo Samaj), and Jewish groups have raised the acceptable minimum age for marriage to 18 years. Buddhists do not promote particular viewpoints on optimum age for marriage. For some Islamic leaders, acceptable marriageable age is when a girl has reached sexual maturity; other Islamic leaders teach that marriage is allowed between 15 and 18 years of age.

Although traditions tend to prevail over religious teachings, many religious leaders work with communities to increase parental and community awareness about the need to stop child marriage.[24] In Niger (PLAN International)[25] and Yemen (Pathfinders and others; panel 1),[26] programmes include messages about the ideal age for marriage within Friday prayers. Faith-based organisations, such as Tear fund, support church partners in many African countries with their programmes on Guardians of our children's health.[28]

 Published online July 7, 2015 http://dx.doi.org/10.1016/S0140-6736(15)60252-5

Female genital mutilation

Female genital mutilation (FGM) is also known as female genital cutting and female circumcision. FGM is defined by WHO as "all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons".[29] The effects are often devastating. An estimated 101 million girls in Africa have been cut when they were less than 10 years old.[30] Some local religious leaders and medical personnel might uphold the practice.[31]

Christianity[32] and Judaism oppose FGM; however, FGM occurs in some Christian communities in Burkina Faso, Egypt, Ethiopia, and Kenya, who justify it as a traditional, centuries-old practice that maintains a girl's purity by restricting or controlling her sexuality.[33] Indeed, FGM had been widely practised before the introduction of Christianity and Islam,[34] which emphasises the need to distinguish between cultural and faith drivers for attitudes and practice in health care. Islamic scholars differ in opinion; some scholars refer to a jurisprudential principle that there should be no harm to the body and others quote a contested hadith (sayings of the Prophet Mohammed) that allegedly advocated for a lighter type of cutting, thus giving rise to a sunnah (a commendable but not an obligatory practice). However, some Islamic scholars do not accept the authenticity of either the hadith or the practice.[35,36] FGM is not practised in countries with large Buddhist or Hindu populations and it is not supported by either religion.

Several programmes show that elimination of FGM can be achieved rapidly if communities, supported by religious leaders, decide to abandon the practice.[37] Sheikh Ali Gomaa, formerly the Grand Mufti of Egypt and then Sheikh Al-Azhar, issued a fatwa (religious edict) on female circumcision noting that "since medical specialists have come to the consensus that even the least invasive of the circumcision procedures causes harm, FGM is forbidden and should be criminalised".[38] The Shia Grand Ayatullah of Lebanon, Sayed Muhammad Hussein Fadlullah, also issued a fatwa forbidding FGM.[39] FGM is now illegal in 24 African countries and in 12 industrialised countries with migrant populations from FGM-practising countries.[40]

Panel 1: Benefits for child protection by interaction with religious leaders

A project in Yemen underscores the importance of engagement with and education of religious leaders in campaigns to prevent child marriage[26]

After a pilot intervention in Amran, where 57 planned girl child marriages were prevented, the project was scaled up to five governorates. The Ministry of Religious Affairs asked all religious leaders to disseminate messages on the health and social consequences of child marriage in their Friday sermons. Religious leaders reached 419 147 individuals by the end of April, 2009, in the five governorates.

The end of project review concluded that religious leaders provide a critically important role for health education at the community level by helping the health education volunteers in the specialty as well as engaging in broader advocacy efforts in reproductive and child health. They lend credibility to the effort and help reduce cultural sensitivity and increase acceptability of interventions.[26]

Tostan (meaning breakthrough in the west African language of Wolof) is an international non-governmental organisation based in Senegal, west Africa dedicated to putting African communities in charge of their own futures[27]

Although not the sole focus of their work, female genital mutilation (FGM) has become the rallying point for social change in many of the communities. Tostan works through its human rights-based community empowerment programme to help community members to draw their own conclusions about FGM and lead their own movements for change. So far, more than 6788 communities in eight African countries have, in 86 ceremonies, publicly declared their decision to end FGM and child and forced marriage. External assessments have shown the public declarations for abandonment are not yet 100% effective, but are necessary for building the critical mass that does eventually lead to FGM becoming a thing of the past.

"Engagement of local religious leaders is a key priority of the community empowerment programme" said Mohammed Cherif Diop (personal communication), Tostan's Islamic rights specialist and head of child protection, who is working to build a critical mass of faith leaders who show that they support the rights of women.[27]

Immunisation

All major religions support immunisation of children.[41] However, a few Christian and Jewish groups object to vaccines derived using cell lines from aborted fetuses; some groups also claim that immunisation shows a distrust in God.[42] Some faith leaders have disseminated misinformation, for example that some vaccines contravene halal dietary standards or contain contraceptives or sterilisation drugs. Other faith leaders have political and sectarian reasons for forbidding communities to immunise their children. Despite pronouncements on the safety of oral polio vaccine by Nigerian Islamic leaders, oral polio vaccine immunisation is still opposed in some communities. Several factors contribute to the breakdown of confidence in immunisation,[43] including putative covert military operations in collaboration with health workers within these communities.[44] Some religious schools have not supported human papillomavirus (HPV) vaccine immunisation on the moral basis that vaccination of schoolchildren against HPV could lead to conclusions that sexual abstinence before marriage and fidelity thereafter are not necessary.[45]

Although manipulation of some faith leaders for political ends is a serious issue, many examples of faith-based support for immunisation exist, as reviewed by the Joint

***Panel 2:* UNICEF 2013[48]**

"Almost 5000 schools and madrassas promote polio eradication on a monthly basis in Karachi, Pakistan." As a teacher at a madrassa in one of Karachi's poorest areas, Qari Aqeel educates children in the fundamentals of Islam and the Holy Quran. He also tells students, from his own painful experience, what it is like to live with polio. As a devout Muslim, Aqeel takes his role as guardian of the children under his care very seriously. Clear guidelines are given, in an Islamic hadith, about the personal responsibility of every Muslim to care for others; "All of you are guardians, and all of you will be asked about the wellbeing of those who you are responsible for". Aqeel talks to parents and children about the importance of vaccination from an Islamic perspective and tries to personally ensure that every child at the madrassa is vaccinated against polio. Pakistan's Government, with technical and logistic support from UNICEF, has begun to shift its polio communication approach to highlight the risks of the disease and emphasised vaccination as an Islamic responsibility.

As part of this initiative, Aqeel has stepped further into his role as a guardian. In a video shown on Pakistani television, which aims to reach 71 million Pakistani households, Aqeel takes the spotlight away from the politics and misunderstandings that can muddy the dialogue about polio vaccination.

***Panel 3:* Roadmap for faith-based organisations to expand access to HIV treatment[49–55]**

Faith-based organisation (FBO) partners came together with international organisations, donors, governments, and UN representatives to increase and scale up FBO work in providing HIV treatment.[50–52] While meeting participants were travelling to the consultation, a law was signed in Uganda to criminalise homosexuality (in which men have sex with men).

A participant from Uganda described how on returning home, his first task would be to discuss with his staff how to protect health-care service provision to homosexual men in Uganda and how to protect patients and staff in the context of the new law. For him, his staff, and clients, the new law has a very immediate effect on health-care delivery. He was very clear that as a doctor in a faith-based health-care facility, his priority is to protect non-judgmental service provision and the safety of his patients and staff.

Subsequent to the meeting, another participant, Cardinal Peter Turkson (President of the Vatican's Pontifical Council for Justice and Peace), was asked questions about the homosexuality law in Uganda by the media. He made strong statements about the importance of not treating homosexual people as criminals and, at the same time, urged caution on the part of the international community in terms of withdrawing financial aid in response to the law. Some civil society groups also cautioned against aid cuts, arguing that this can negatively affect health-service provision. These kinds of statements are very influential in this highly charged environment.

Outcomes from this meeting build on recommended roles and responsibilities of faith-based organisations and international partners as articulated in the UNAIDS Strategic Framework for Partnership with FBOs. Adherence to such principles of mutual respect and the provision of non-judgmental, evidence-informed health care by both FBO and secular partners is essential.

The Indian Interfaith Coalition on AIDS engages with religious leaders as mediators of hope in their respective communities, creating a stigma-free and discrimination-free response. The group has been influential in motivating the Hindu community response and encourages other major Indian faiths (Islam and Christianity) to work through their faith leaders to mobilise an effective response around HIV/AIDS.

Learning Initiative on faith and local communities (JLIFLC).[46] Additionally, some Catholic groups in the USA support HPV immunisation for schoolgirls and oral polio vaccine is supported by Islamic groups in Pakistan[47] and Nigeria. Fatwas by Islamic scholars about the benefits of immunisation and collaboration between imams and UNICEF have helped immunisation in thousands of Koranic schools in Pakistan (panel 2). Many faith communities now promote and deliver immunisation in countries where it had previously been opposed.

Stigma and sexuality

Many faith communities have responded to HIV,[56] taking major steps to reduce stigma and discrimination and provide widespread health care and support; unfortunately, other communities have not. Stigmatising attitudes and behaviours towards people with HIV, or thought to have HIV, result from a range of cultural attitudes, traditional practices, laws, and interpretations of religious beliefs; these views are serious obstacles to the HIV response.[57] Many people experience stigma after declaring their HIV status. However, the International Network of Religious Leaders living with or personally affected by HIV or AIDS (INERELA) website describes how religious leaders living with HIV in Africa and Asia now live and work with integrity and respect.[58] The World Vision Channels of Hope methods,[59] the INERELA+SAVE toolkit,[60] and Tearfund training materials[61] build on the positive aspects of faith teachings, which include HIV, human rights, sexuality, and gender.

One area of controversy is homosexuality. Although Hinduism accepts homosexuality and Buddhist viewpoints vary on its acceptance, traditional interpretations of Christian, Islamic, and Jewish scriptures state that sexual activity should be restricted to between one man and one woman within the context of marriage, and homosexual acts are not accepted.[62,63] This contrasts with the lived experience of people who

are lesbian, gay, bisexual, or transgender (LGBT) for whom this is not a lifestyle choice but an expression of their identity.[64] UNAIDS reports that 63 countries criminalise some aspect of HIV (including non-disclosure, exposure, or transmission) and 78 countries criminalise consensual same-sex sexual behaviour. UNAIDS clearly states that the criminalisation of HIV transmission and homosexuality has a negative effect on HIV and health-care provision; ending punitive laws will support access to life-saving HIV services.[65,66]

Some Christian leaders challenge traditional interpretations of scriptures, and some churches now offer blessings on, or perform, same-sex marriage.[67] Although some religious leaders support criminalisation of same-sex behaviour, prominent Buddhist, Christian (Anglican and Catholic), and Muslim leaders strongly condemn stigma, discrimination, and violence towards people who are LGBT.[68–70] Jewish law also teaches that all people should receive medical care and empathy, regardless of their lifestyle, although same-sex relationships are strictly prohibited.

The interventions by faith-inspired individuals, including politicians, in persuading the former US President George W Bush and a sceptical US Congress to launch PEPFAR (the President's Emergency Program for AIDS Relief) in 2003 have been described, including the emphasis on abstinence-only methods for prevention of HIV and non-use of US funds for abortion-related activities.[71] Much of PEPFAR funding was channelled through faith-based health-care providers in Africa, building on long-standing medical missionary work. Some argue that US faith groups have contributed to criminalisation of homosexuality in Africa.[72,73] However, attribution of development of laws to single influences of faith, political leadership, or culture is not easy and can be unhelpful. The more nuanced complexity is shown by an example in Uganda (panel 3).

Harm reduction and HIV

Harm reduction interventions to prevent HIV transmission include opiate substitution therapy, needle exchange for people who inject drugs, condom use, male circumcision, postexposure prophylaxis, postoccupational exposure to HIV in health settings and rape, pre-exposure prophylaxis, and the use of treatment for the prevention of HIV transmission. Objections to harm reduction interventions include collusion with continuing unhealthy behaviour, thereby diverting attention from the primary need for behavioural change. However, there is much support for harm reduction from sacred texts,[53] and many faith-inspired organisations, including Buddhist, Christian, Hindu, and Islamic, provide a wide range of harm reduction services in their HIV response, such as clean needles and condoms. Needle exchange is supported in predominantly Islamic Malaysia.[54] Hindu groups support HIV prevention in India and many Christian groups provide male circumcision in HIV-affected communities. Buddhist groups[10] support harm reduction HIV services in Cambodia, China, Laos, Thailand, and Vietnam, including mindfulness as a supportive component for seeking to achieve behavioural change among those with addiction to intravenous drugs.[73] The Indian Interfaith Coalition on AIDS (IICA), involving faith leaders and health professionals from Hindu, Christian, and Islamic faiths, speak out against criminalisation of homosexuality and support provision of health-care services to vulnerable populations.

Panel 4: Gender-based violence[74–76]

Alhough often prevalent in conflict and humanitarian contexts, sexual violence is common within communities worldwide, but as an issue that is largely hidden. Women, girls, men, and boys are all at risk of sexual violence. Today, many women (in some countries, as many as one in three) are beaten, coerced into sex, or otherwise abused in their lifetimes. Worldwide, one in five women will become a victim of rape or attempted rape in her lifetime. Gender-based violence increases the risk of HIV infection and contributes to malnutrition in women and their children.[76]

In May, 2014, the UK Government hosted the Ending Sexual Violence in Conflict Meeting in London, UK, in which the role of faith leaders as a first port of call for many survivors of sexual violence was prominent.

We will speak out (WWSO)

WWSO is a worldwide coalition of Christian-based non-governmental organisations, churches, and organisations supported by an alliance of technical partners and individuals who together commit themselves to see the end of sexual violence across communities around the world.[77] The WWSO coalition is dedicated to empowering women and girls, transforming relationships between women and men, and ensuring that the voices of survivors of sexual violence—women, girls, men, and boys—are central to their work.

Violence against women

WHO defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. Violence against women contributes to many fatalities and serious consequences for women and their children,[75] both physical and psychological, and is prevalent in many countries.[78]

Buddhism, Christianity, and Judaism oppose violence against women. Indeed, Catholic bishops in the USA, Uganda, and Ethiopia, among others, draw attention to the need for pastoral care.[79] The Archbishop of Canterbury highlights the work of the Anglican Church in Democratic Republic of the Congo and elsewhere.[80] Within Hinduism, some traditional texts specify that women should be honoured but not encouraged to think

***Panel 5*: Quote from Archbishop Desmond Tutu at the Women, Faith, and Development Alliance Breakthrough Summit at Washington National Cathedral, April, 2008[88]**

"Despite its global leadership on human rights and humanitarian aid, the faith community has failed to champion gender justice and the cause of women and girls. Religion has too often been used as a tool to oppress women, and we must bear responsibility for contributing to the unjust burden borne by women. Too often we have not named, and condemned roundly, culturally and traditionally rooted discriminatory practices like child marriage, genital mutilation and violence against women and children."

"We need courageous faith leadership, rooted in our common understanding of the dignity and value of each human person. We must come together as people of faith and stand up for women and girls by addressing these issues from every pulpit and platform in synagogues, mosques, churches and other places of worship. The interfaith community must join with leaders in other sectors to press for more resources so that women and girls can change their own lives and those of their families and communities."

for themselves.[81] Coupled with karma theory that accepts suffering (including domestic violence) as payment for sins committed in a previous life, a strong tendency to accept violence against women or view it with complacency exists;[82] however, international protest against rape has occurred, and the Prime Minister of India, a Hindu, has publicly named rape as a national shame.[83] Islamic teachers vary; there is a word—idrabahunna—within a Quranic verse that has been interpreted by some to justify the beating of wives, but many Islamic scholars do not accept any interpretations justifying violence.

Imams Against Domestic Abuse works with religious leaders and communities to make them more aware and active against all forms of violence against women, using the authority of the Quran and the Sunnah to protect them.[84] Saudi Arabia has made violence against women illegal. We Will Speak Out (WWSO; panel 4)[77] is a worldwide coalition of Christian-based non-governmental organisations, churches, and organisations working in advocacy against violence against women.

For the **WWSO** see www.wewillspeakout.org

Gender

According to WHO, sex refers to the biological and physiological characteristics that define men and women, whereas gender refers to the socially constructed roles, behaviours, activities, and attributes that a particular society deems appropriate for men and women.[85] The term gender, however, is not without controversy in some faith communities and within various cultures.[86] According to some health experts and human rights advocates, absence of specific terminology can lead to reinforcement of harmful patterns of behaviour or to turning a blind eye to inequalities, particularly those experienced by women in the provision and access of health-care services;[87] however, many faith leaders oppose such deprecating and damaging viewpoints about women (panel 5).

Faith activities

All religions believe that God or a superior force can intervene for the prevention and treatment of illness as a response to personal prayer, meditation, reading of sacred texts, or healing services. Such faith activities are often done in the hope that they will incrementally boost medical treatment and bring personal peace and healing.[89,90] Although prayer offered by hospital chaplains and faith leaders is widely provided, strict guidelines exist, with disciplinary procedures in some countries,[91] for doctors and nurses who offer prayer. Safeguarding of patients is important so that they are not pressurised by zealous proselytising individuals. Spiritual aspects of health care are therefore often excluded. In other countries, however, prayer for patients by staff is widely offered and evidently welcomed. Unfortunately, few data exist for the types of faith activities that patients would appreciate in different cultures. Concern that humanitarian activities should not be offered to promote a particular religious standpoint is enshrined in the SPHERE guidelines,[92] but many people affected by disasters live in countries where religion is practised widely and on a daily basis. Data are inadequate for the type of faith activities that such populations might value in times of illness or crisis, alongside humanitarian relief and psychosocial counselling. Judaism advocates combination of prayers and effective medical treatment.

Some (eg, specific Pentecostal African) groups emphasise dependence on prayer, which is promoted in congregations and TV channels, with advice not to take medical treatment.[93] The popularity of healing missions, especially for those with disability and long-term illness, is well documented; however, the long-term effect of these missions on physical and mental health is not. Combinations of prayer within major faith systems and traditional belief systems,[94] including sacrifices, appeasement ceremonies, and talismans, are common, but their effectiveness is unknown.

Buddhism emphasises the importance of seeking peace and freedom from pain, even in the presence of disease. Traditional healing ceremonies, together with informal counselling and HIV prevention messages, are offered by Buddhist groups throughout southeast Asia. Cooperation between the Yunnan AIDS bureau and the Sipsongpanna Buddhist Association provides community care and support in China. Traditional healing customs, such as Ayurveda in Hinduism, are widely practised and include consultation with local healers, retributive prayers, and meditation before going to practitioners of scientific medical care. Belief in a spiritual cause for illness and the need for casting out of evil spirits for

treatment of illness, especially mental illness and epilepsy,[95] occurs in many countries, including some in Europe.[96] The scale of such practices and the extent to which they contribute to improvement in health status or delay in accessing effective health care is largely unknown. National religious councils and faith-based health associations are reportedly increasingly active in educating and working with local traditional healers to improve access to effective health care, but there are few robust descriptions of such partnerships, their activities, or their effect.

End-of-life issues

Different faith-based viewpoints about end-of-life issues have been reviewed previously in *The Lancet*.[97] Much advocacy by secular groups[98] exists towards changing existing laws that prosecute health professionals for being involved with the killing or assisted suicide of patients, as evidenced by the law changes in Belgium, which now allow euthanasia and assisted suicide in children. Many faith-based groups strongly oppose killing of patients or assisting with their suicide; they are vigourously supported by palliative care health professionals.[99] Indeed, faith-based groups are at the forefront of developing palliative care services. Buddhism, Christianity, Islam, and Judaism reject euthanasia and assisted suicide, even when the patient requests it.[100] Rather, these religions support the appropriate provision or withholding of specific intensive medical treatments upon the wish of the dying and provide palliative care, including spiritual support.[101] Hindus teach that although a person can be released from suffering, by euthanasia for example, it is undesirable. WHO's description of appropriate interventions for palliative care recognises both spiritual and psychological aspects of care,[102] whereas the overall description of health (omitting spiritual) by WHO is secular.

Recommendations

A disturbing dearth of analysis of health-care-related controversies between and within religion exists; innovative research and documentation processes and programmes are urgently needed.[103] Our Series paper merely identifies some faith-related factors affecting policy and practice in health care; deeper research, consideration, and action are needed.

Clinicians should become better informed about the faith drivers that affect their patient's attitudes, prejudices, behaviours, response to illness, and desire for health-care services if they are to provide professional, compassionate, and empathetic care respecting a patient's autonomous wishes.[104] These issues are complex and our paper is merely an introduction, providing references for deeper reading. Review of how different faith-inspired groups promote and deliver health care with integrity and professionalism is really needed, especially in poor, marginalised, and unreached populations that are not adequately served by government services. The accompanying review on faith-based health care in Africa in this *Lancet* Series is important.[105] The Joint Learning Initiative for Local Faith Communities,[106] the Berkley Centre for Faith and Health at Georgetown University, USA,[2] the George Washington Institute for Spirituality and Health, USA,[107] and the International Religious Assets Programme at Cape Town University, South Africa,[108] are also making important contributions, but more needs to be done.

Faith leaders could review their interpretation of sacred texts carefully in view of contemporary biomedicine, especially when differing viewpoints are held within the same religion. Analysis of the interaction between culture, politics, and faith is particularly important so that faith leaders and faith faculties can become more aware of how their faith-based viewpoints might become manipulated. As faith leaders become more aware of the effect of their teaching on patterns of health care, they might be astonished at how influential they are. Faith leaders could use their faith messages more effectively to inspire their congregations to adopt healthy behaviours and access effective health-care services much more frequently and effectively.

Many international agencies and some national health programmes reject any faith dimension and omit any spiritual dimension to health care. Greater analysis is needed about the ways that pressure groups, with secular agendas, campaign to keep faith out of health in the same way as faith groups are identified, and often vilified, when promoting faith-based agendas for health care and health-care policy. Such policy conflicts are rarely reported in peer-reviewed scientific literature.[109,110] At the very least, health-care policy makers could look above their secular silos at what has been achieved by engagement with faith-inspired health-care groups; they too might be astonished at the results.

Health professionals, faith leaders, and policy makers are urgently needed to move out of their discrete disciplines and work together for improving health care. Robust markers already exist to assess the prevalence of child marriage, FGM, and immunisation coverage, as outlined in the reports on the State of the World's Children by UNICEF. Similar markers exist for stigma and violence against women, as well as strong published work on the variations in uptake rates for HIV/AIDS services. These indicators need to be developed to provide increased analysis and understanding of factors affecting health care, both within and between faith groups. Collaborative research should be methodologically rigorous and provide an evidence base for changes in policies and programmes. The present, all too common, practice of berating or ignoring faith groups, often on the basis of hearsay, is totally unacceptable.

Contributors
All authors contributed to the design of this Series paper and participated in discussions on the different sections and emphases. All authors read, revised, and critiqued the successive versions and agreed on the final manuscript. AT coordinated the paper.

Declaration of interests
We declare no competing interests.

Acknowledgments
The writing of this Series paper, and the review process by the *Lancet* Working Group on Faith and Global Health was supported by Capital for Good.

References

1 Pew Research Center. The Global Religious Landscape. 2010. www.pewforum.org/2012/12/18/global-religious-landscape-exec/ (accessed June 29, 2014).
2 Berkley Center for Religion, Peace and World Affairs. Resources on Faith, Ethics, and Public Life. http://berkleycenter.georgetown.edu/resources (accessed May 26, 2014).
3 Steinberg A. Bioethics: secular philosophy, Jewish law and modern medicine. *Isr J Med Sci* 1989; **25:** 404–09.
4 Steinberg A. Abortion for fetal CNS malformations: religious aspects. *Childs Nerv Syst* 2003; **19:** 592–95.
5 Nuffield Council on Bioethics. Public health: ethical issues. http://nuffieldbioethics.org/project/public-health (accessed May 21, 2015).
6 Keown D. Buddhism and bioethics. London: Palgrave MacMillan, 1995: 1–224.
7 The Holy See. Conception and the Catechism of the Catholic Church. www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm (accessed May 21, 2015).
8 Coward H, Sidhu T. Bioethics for clinicians: 19. Hinduism and Sikhism. *CMAJ* 2000; **163:** 1167–70.
9 Burton E, Fergusson A. Members' Attitudes to abortion: a survey of reported views and practice. Christian Medical Fellowship, UK. 1996.
10 Serour GI. Ethical issues in human reproduction: Islamic perspectives. *Gynecol Endocrinol* 2013; **29:** 949–52.
11 Schenker JG. Human reproduction: Jewish perspectives. *Gynecol Endocrinol* 2013; **29:** 945–48.
12 Harvey P. An introduction to Buddhist ethics. Cambridge: Cambridge University Press, 2000.
13 The Holy See. Family Planning and the catechism of the Catholic Church. www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a6.htm (accessed May 21, 2015).
14 Fadel HE. Developments in stem cell research and therapeutic cloning: Islamic ethical positions, a review. *Bioethics* 2012; **26:** 128–35.
15 Stephens M, Jordens CF, Kerridge IH, Ankeny RA. Religious perspectives on abortion and a secular response. *J Relig Health* 2010; **49:** 513–35.
16 Steinberg A. Encyclopedia of Jewish medical ethics, vol 2. Jerusalem and New York: Feldheim, 2003.
17 Yeatman SE, Trinitapoli J. Beyond Denomination: The Relationship between Religion and Family Planning in Rural Malawi. *Demogr Res* 2008; **19:** 1851–82.
18 The Holy See. Abortion and the catechism of the Catholic Church. www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm (accessed May 21, 2015).
19 Wyatt J. Matters of Life and Death. Nottingham: Inter Varsity Press, 2009: 1–303.
20 Best M. Fearfully and Wonderfully Made. Sydney: Matthias Media, 2012: 1–522.
21 Moad EO. Hindu ethics on the moral question of abortion. http://www.eubios.info/EJ144/ej144j.htm (accessed May 21, 2015).
22 Serour GI, Dickens BM. Assisted reproduction developments in the Islamic world. *Int J Gynaecol Obstet* 2001; **74:** 187–93.
23 Young MT. End child marriage.UNFPA, 2012. www.unfpa.org/public/home/publications/pid/12166 (accessed May 21, 2015).
24 Plan International Engaging religious leaders to end child marriage. http://plan-international.org/where-we-work/africa/niger/what-we-do/our-successes/engaging-religious-leaders-to-end-child-marriage (accessed May 21, 2015).
25 Plan International. Engaging religious leaders to end child marriage in Niger. www plan-international org 2014; http://plan-international.org/where-we-work/africa/niger/what-we-do/our-successes/engaging-religious-leaders-to-end-child-marriage/?searchterm=Niger%20and%20Child%20Marriage (accessed May 21, 2015).
26 USAID. Yemen Basic Health Services Project (2006–2010) Final Report, March 2011. http://pdf usaid gov/pdf_docs/pdacw754.pdf (accessed May 21, 2015).
27 Tostan. Dignity for all. News and resources. http://www.tostan.org./news-resources (accessed May 21, 2015).
28 Tearfund. Guardians of our Children's Health Toolkit. Activities for church groups to involve men and women in preventing parent to child transmission of HIV http://tilz.tearfund.org/~/media/Files/TILZ/HIV/GOOCH%20English%20Manual%20FINAL.pdf (accessed May 21, 2015).
29 WHO. Female Genital Mutlilation. www.who.int/topics/female_genital_mutilation/en (accessed May 21, 2015).
30 UNFPA and UNICEF. UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Annual Report 2012. Scaling Up a Comprehensive Approach to Abandonment in 15 African Countries. 2013. http://www.unfpa.org/publications/unfpa-unicef-joint-programme-female-genital-mutilationcutting-annual-report-2012#sthash.2z4pe3Ec.dpuf (accessed May 21, 2015).
31 Habibzadeh F. Female genital mutilation in the Middle East. *Lancet* 2013; **382:** 1.
32 The Holy See. Bodily mutilation and the catechism of the Catholic Church. www.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a5.htm (accessed May 21, 2015).
33 Hayford SR, Trinitapoli J. Religious differences in female genital cutting: a case study from Burkina Faso. *J Sci Study Relig* 2011; **50:** 252–71.
34 Yount K. Symbolic Gender Politics, Religious Group Identity and the Decline in Female Genital Cutting in Minya, Egypt. *Soc Forces* 2004; **80:** 1063–90.
35 Religious Tolerance. Debates about FGM in Egypt: before 2007. www.religioustolerance.org/fem_cirm3.htm#mufti (accessed May 21, 2015).
36 Imad-ad-Dean Ahmad. Female genital mutilation: an Islamic perspective. http://www.minaret.org/fgm-pamphlet.htm (accessed May 21, 2015).
37 UNFPA and UNICEF New and existing partnerships with religious and traditional leaders in UNFPA-UNICEF joint programme on female genital mutilation/cutting. http://www.unfpa.org/sites/default/files/pub-pdf/Annual_report_on_FGM-C_2011_low_res.pdf (accessed May 21, 2015).
38 Islamopedia. Grand Mufti of Egypt Ali Gomaa denounces female circumcision and calls the practice a punishable offense following an international Islamic conference of scholars. http://www.islamopediaonline.org/fatwa/grand-mufti-egypt-ali-gomaa-denounces-emale-circumcision-and-calls-practice-punishable-offense (accessed May 21, 2015).
39 Islamopedia. Grand Ayatollah Fadlallah responds to the question: "Is it true that Islam intends to inhibit and control lust in women with circumcision?" http://www.islamopediaonline.org/fatwa/grand-ayatollah-fadlallah-responds-question-it-true-islam-intends-inhibit-and-control-lust-wom (accessed May 21, 2015).
40 UNFPA. Eliminating female genital mutilation in strategic approaches. http://www.unfpa.org/topics/genderissues/fgm/strategicapproaches (accessed May 21, 2015).
41 Grabenstein J. What the world's religions teach, applied to vaccines and immune globulins. *Vaccine* 2013; **31:** 2011–23.
42 Ruijs WL, Hautvast JL, van der Velden K, de Vos S, Knippenberg H, Hulscher ME. Religious subgroups influencing vaccination coverage in the Dutch Bible belt: an ecological study. *BMC Public Health* 2011; **11:** 102.
43 Antai D. Inequitable childhood immunization uptake in Nigeria: a multilevel analysis of individual and contextual determinants. *BMC Infect Dis* 2009; **9:** 181.
44 Tomkins AM. Losing Trust—why immunisation programmes fail. http://www.cmfblog.org.uk/2013/04/23/losing-trust-why-immunisation-programmes-fail/ (accessed May 21, 2015).
45 Smith SD. The HPV Vaccine: ongoing ethical and policy issues. *Univ Toronto Med J* 2007; **88:** 16–18.

46 Olivier J. Local faith communities and immunization for community and health system strengthening. Report for the Joint Learning Initiative on Faith and Local Communities, 2014. http://jliflc.com/resources/annotated-bibliography-local-faith-communities-immunization-community-health-systems-strengthening/ (accessed May 21, 2015).

47 Ahmed QA, Nishtar S, Memish ZA. Poliomyelitis in Pakistan: time for the Muslim world to step in. *Lancet* 2013; **381:** 1521–23.

48 UNICEF. State of the World's Children. 2013. www unicef org/sowc2013 www.unicef.org/sowc2013 (accessed May 21, 2015).

49 Vatican Insider. Cardinal Turkson defends gays against unfavourable Ugandan law. http://vaticaninsider.lastampa.it/en/news/detail/articolo/gays-uganda-turkson-32493/ (accessed May 22, 2015).

50 UNAIDS. Roadmap for faith-based organisations to expand access to HIV services. http://www.unaids.org/en/resources/presscentre/featurestories/2014/february/20140227fboconsultation (accessed May 22, 2015).

51 UNAIDS. Partnership with faith-based organisations UNAIDS Strategic Framework. www.unaids.org/sites/default/files/media_asset/20100326_jc1786_partnership_fbo_en_0.pdf (accessed May 21, 2015).

52 Inerela. AIDS 2014: faith based campaigners to step up response to HIV. http://inerela.org/2014/07/aids-2014-faith-based-campaigners-to-step-up-response-to-hiv/ (accessed May 21, 2015).

53 Hughes D. Friend of "sinners". Letter in Triple Helix. http://admin.cmf.org.uk/pdf/helix/sum09/th45.pdf (accessed May 22, 2015).

54 Kamarulzaman A. Fighting the HIV epidemic in the Islamic world. *Lancet* 2013; **381:** 2058–60.

55 Integrated Regional Information Networks (IRIN). Laos: regional Buddhist HIV outreach programme making an impact. www.irinnews.org/report/70800/laos-regional (accessed May 22, 2015).

56 Smith S. Multi-sector realities in the global response to HIV/AIDS, vol 2. In O'Donnell K, Lewis O'Donnell M, eds. Global member care: crossing sectors for serving humanity. Pasadena, CA: William Carey Library Publishers, 2014: 37–55.

57 UNAIDS. UNAIDS Global Report on the AIDS epidemic, 2012. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf (accessed May 21, 2015).

58 Inerela. Inerela's core business is to eradicate all forms of stigma and discrimination and preserve human dignity. http://inerela.org/about-us/what-we-do (accessed May 21, 2015).

59 World Vision International. Channels of hope. Igniting a movement to transform communities. http://www.wvi.org/health/publication/channels-hope (accessed May 21, 2015).

60 Inerela. Inerela save toolkit. www inerela org/resources/save-toolkit/ 2014;Avaiable from: URL: www.inerela.org/resources/save-toolkit (accessed May 21, 2015).

61 Tearfund International Learning Zone. Preventing Parent to Child Transmission. http://tilz.tearfund.org/en/themes/hiv/preventing_parent-to-child_transmission/ (accessed May 22, 2015).

62 Downes G. The bible and homosexuality part 2. http://www.premierchristianity.com/Featured-Topics/Homosexuality/The-Bible-and-Homosexuality-Part-Two (accessed May 21, 2015).

63 The Holy See. Homosexuality and the Catechism of the Catholic Churchwww.vatican.va/archive/ccc_css/archive/catechism/p3s2c2a6.htm (accessed May 21, 2015).

64 Clark F. Discrimination against LGBT people triggers health concerns. *Lancet* 2014; **383:** 500–02.

65 UNAIDS. UNAIDS Global Report on the AIDS epidemic, 2013. Eliminate HIV related Stigma, Discrimination, Punitive Laws and Practices.http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf (accessed May 21, 2015).

66 UNAIDS. UNAIDS Guidance on criminalisation of HIV exposure and transmission: critical scientific, medical, and legal considerations,2013. www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130530_Guidance_Ending_Criminalisation.pdf (accessed May 21, 2015).

67 Chalke S. The bible and homosexuality part 1. http://www.premierchristianity.com/Featured-Topics/Homosexuality/The-Bible-and-Homosexuality-Part-One (accessed May 21, 2015).

68 Catholic News Service. 'Who am I to judge a homosexual person?' Pope's remarks do not change church teaching.http://www.catholicnews.com/data/stories/cns/1303303.htm (accessed May 21, 2015).

69 The House of Bishops. Working group on human sexuality. Report of the House of Bishops, November 2013. https://www.churchofengland.org/media/1891063/pilling_report_gs_1929_web.pdf (accessed May 21, 2015).

70 Esack F, Mahomed N. Sexual diversity, Islamic jurisprudence and sociality. *JGRA* 2011; **17:** 41–57.

71 Marshall K. Aid effectiveness and faith-inspired organisations. Policy brief. Berkley Center for Religion, Peaace, and World Affairs, Georgetown University. http://repository.berkleycenter.georgetown.edu/130101WFDDPolicyBriefAidEffectivenessFaithInspiredOrganizations.pdf (accessed May 21, 2015).

72 PEPFAR. A firm foundation. http://www.pepfar.gov/documents/organization/195614.pdf (accessed May 22, 2015).

73 Kaoma K. Globalizing the culture wars. US conservatives, African churches, and homophobia. http://www.publiceye.org/publications/globalizing-the-culture-wars/pdf/africa-full-report.pdf (accessed May 22, 2015).

74 UNAIDS. Uniting against violence and HIV. www.unaids.org/en/resources/presscentre/featurestories/2014/march/20140312xcsw. (accessed May 21, 2015).

75 Yount KM, DiGirolamo AM, Ramakrishnan U. Impacts of domestic violence on child growth and nutrition: a conceptual review of the pathways of influence. *Soc Sci Med* 2011; **72:** 1534–54.

76 Global Report UNAIDS. 2013. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf. (accessed May 21, 2015).

77 We will speak out (WWSO). www.wewillspeakout.org (accessed May 21, 2015).

78 Watts C, Zimmerman C. Violence against women: global scope and magnitude. *Lancet* 2002; **359:** 1232–37.

79 United States Conference of Catholic Bishops. When I call for help: a pastoral response to domestic violence against women. http://www.usccb.org/issues-and-action/marriage-and-family/marriage/domestic-violence/when-i-call-for-help.cfm (accessed May 22, 2015).

80 Justin Welby the Archbishop of Canterbury. Archbishop Justin visits project combating sexual violence in Goma http://www.archbishopofcanterbury.org/articles.php/5246/archbishop-justin-visits-project-combating-sexual-violence-in-goma (accessed May 22, 2015).

81 Rambachan A. A Hindu perspective on Women. http://www.sunypress.edu/pdf/60256.pdf (accessed May 22, 2015).

82 Young KK. Women in Hinduism Today in Today's Woman in World Religions. Albany: State University of New York Press, 1994.

83 Prime Minster Modi on rape cases: correct sons, don't question daughters. http://www.ndtv.com/article/india/pm-modi-on-rape-cases-correct-sons-don-t-question-daughters-576261 (accessed May 22, 2015).

84 Islamic Relief Worldwide. Effective peer education on violence against women. http://www.islamic-relief.org/feature-standing-up-against-violence/ (accessed May 22, 2015).

85 WHO. What is Gender? http://www.who.int/gender/whatisgender/en/ (accessed May 22, 2015).

86 Monash University Medicine, Nursing, and Health Services. What is the difference between sex and gender? http://www.med.monash.edu.au/gendermed/sexandgender.html (accessed May 22, 2015).

87 Chitando E, Chirongoma S. Redemptive Masculinities: Men, HIV, and Religion. Geneva: World Council of Churches Publications, 2012. https://www.oikoumene.org/en/resources/documents/wcc-programmes/justice-diakonia-and-responsibility-for-creation/ehaia/redemptive-masculinites (accessed May 22, 2015).

88 Berkley Center for Religion, Peace, and World Affairs. Women, faith and development Alliance. http://berkleycenter.georgetown.edu/organizations/women-faith-and-development-alliance (accessed May 21, 2015).

89 Koenig HG, Larson DB, Larson SS. Religion and coping with serious medical illness. *Ann Pharmacother* 2001; **35:** 352–59.

90 Koenig HG, McCullough ME, Larson DB. Handbook of Religion and Health. Oxford: Oxford University Press, 2001: 1–700.

91 General Medical Council. Personal beliefs and medical practice, 2013. http://www.gmc-uk.org/guidance/ethical_guidance/21171.asp (accessed May 22, 2015).

92 The Sphere Project. The Sphere handbook. http://www.sphereproject.org/handbook/ (accessed May 22, 2015).

93 Thielman NM, Ostermann J, Whetten K, et al, and the CHAT Research Team. Reduced adherence to antiretroviral therapy among HIV-infected Tanzanians seeking cure from the Loliondo healer. *J Acquir Immune Defic Syndr* 2014; **65:** e104–09.

94 Evans-Pritchard E. Witchcraft, Oracles and Magic among the Azande. Oxford: Oxford University Press, 1976: 1–265.

95 Elafros MA, Sakubita-Simasiku C, Atadzhanov M, Haworth A, Chomba E, Birbeck GL. Stigma and psychiatric morbidity among mothers of children with epilepsy in Zambia. *In Health* 2013; **5:** 288–94.

96 Beer D, Pocock N. Mad, Bad or Sad. Beer MD, Pocock ND, eds. Christian Medical Fellowship, 2006.

97 Mahawar KK. End-of-life issues. *Lancet* 2005; **366:** 1848.

98 Dignity in dying. Assisted dying. http://www.dignityindying.org.uk/assisted-dying/ (accessed May 22, 2015).

99 Care not Killing. What we do. http://www.carenotkilling.org.uk/about/what-we-do/ (accessed May 22, 2015).

100 Hollins S. Religions, culture and healthcare: a practical handbook for use in healthcare environments. Radcliffe Medical PR, 2009.

101 Hartwig KN, Hartwig KA, DiSorbo P, et al. Scaling up a community-based palliative care program among faith-based hospitals in Tanzania. *J Palliat Care* 2010; **26:** 194–201.

102 WHO. Palliative care is a crucial part of cancer control. http://www.who.int/cancer/palliative/en/ (accessed May 22, 2015).

103 Widmer M, Betran AP, Merialdi M, Requejo J, Karpf T. The role of faith-based organizations in maternal and newborn health care in Africa. *Int J Gynaecol Obstet* 2011; **114:** 218–22.

104 Gatrad R, Brown E, Sheikh A. Palliative care for south Asians: Muslims, Hindus and Sikhs. London: Quay Books, 2000.

105 Olivier J, Tsimpo C, Gemignani R, et al. Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *Lancet* 2015; published online July 7. http://dx.doi.org/10.1016/S0140-6736(15)60251-3.

106 Joint Learning Initiative on Faith and Local Communities. About the resilience hub. http://resilience.jliflc.com/resilience-hub-2/ (accessed May 22, 2015).

107 George Washington Institute for Spirituality and Health. About GWish. www.https://smhs.gwu.edu/gwish/about (accessed May 22, 2015).

108 International Religious Health Assets Programme, University of Cape Town, South Africa. About IRHAP. http://www.arhap.uct.ac.za/about.php (accessed May 22, 2015).

109 Lobbying for Faith and Family: a study of religious NGOs at the United Nations. http://www.norad.no/globalassets/import-2162015-80434-am/www.norad.no-ny/filarkiv/vedlegg-til-publikasjoner/lobbying-for-faith-and-family.pdf (accessed May 22, 2015).

110 Karpf T. Faith and health: past and present of relations between faith communities and the World Health Organisation. *CJGH* 2014; **1:** 16–25.